# Florida Network for Youth and Family Services
# Compliance Monitoring Report for

**CHS WaveCREST**
**4520 Selvitz Road,**
**Fort Pierce, FL 34981**

**Compliance Monitoring Services Provided by**

## EXECUTIVE SUMMARY

Forefront LLC conducted a joint Modified Quality Improvement (QI) and Florida Network of Youth and Family Services (FNYFS) monitoring visit for CHS WaveCREST for the FY 2021-2022 at its program office located at 4520 Selvitz Road, Fort Pierce, Florida. Forefront LLC (Forefront) is an independent compliance monitoring firm that is contracted by the FNYFS to perform onsite program reviews to assess the agency's adherence to fiscal, programmatic and overall contract requirements. CHS WaveCREST is contracted with the Florida Network of Youth and Family Services (FNYFS) to provide direct services to Children/Families in Need of Services (CINS/FINS). The services to be provided are identified in Contract Section A - Descriptions and Specifications and Section B - Delivery and Performance and are funded with General Revenue Funds effective for July 2021 through June 30, 2022.

The review was conducted by Marcia Tavares, Consultant for Forefront LLC, and Peer Reviewer(s). Agency representatives from CHS WaveCREST present for the entrance interview were Sabrina Sampson, Executive Director (by phone); Kristi Walsh, Director of Program Operations; Kelly Barnett, Residential Supervisor; Brittany Brown, Community Counseling Program Supervisor; and Ronnie Lauer, Talent Generalist Manager (by phone). The last QI visit was conducted December 16 -17, 2020.

In general, the Reviewer found that CHS WaveCREST is in compliance with specific contract requirements. **CHS WaveCREST received an overall compliance rating of 75% for achieving** compliance with three of four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. There were no corrective actions as a result of the monitoring visit; however, one recommendation was made for an indicator rated as conditionally acceptable due to the pending completion of the Single Audit that is overdue based on contract requirement.

The following report represents the results of the in-depth evaluation of the provider's General Administrative performance, with all findings clearly documented. Copies of all completed tools utilized during the visit to determine these ratings will be maintained on file with the Reviewer. If any information or clarification is required, please contact Keith Carr by E-mail: keithcarr@forefrontllc.com

# 2021-2022 MODIFIED CINS/FINS PROGRAM COMPLIANCE MONITORING TOOL
## Report Number: CM 02-16-2021-2022

| Agency Name: CHS WaveCREST | Monitor Name: Marcia Tavares, Lead Reviewer |
|---|---|
| Contract Type : CINS/FINS | Region/Office: 4520 Selvitz Road, Fort Pierce, FL |
| Service Description: Comprehensive Onsite Compliance Monitoring | Site Visit Date(s): February 16 – 17, 2022 |
| | |

| Major Programmatic Requirements | Explain Rating | | | | | Ratings Based Upon: I = Interview O = Observation D = Documentation PTV = Submitted Prior To Visit (List Who and What) | Notes Explain Unacceptable or Conditionally Acceptable: (Attach Supportive Documentation) |
|---|---|---|---|---|---|---|---|
| | Unacceptable | Conditionally Unacceptable | Fully Met | Exceeded | Not Applicable | | |
| **I. Administrative and Fiscal** | | | | | | | |
| **Limits of Coverage**<br>a. Provider shall provide and maintain during this contract, the following minimum kinds of insurance: Worker's Compensation and Employer's liability insurance as required by Chapter 440, F.S. with a minimum of $100,000 per accident, $100,000 per person and $500,000 policy aggregate. Commercial General Liability with a limit of $500,000 per occurrence, and $1,000,000 policy aggregate. Automobile Liability Insurance shall be required and shall provide bodily injury and property damage liability covering the operation of all vehicles used in conjunction with performance of this contract, with a minimum limit for bodily injury of $250,000 per person; with a minimum limit for bodily injury of $500,000 per accident; with a minimum limit for property damage of $100,000 per accident and with a minimum limit for medical payments or $5,000-$10,000 per person. Florida Network is listed as payee or co-payee. **PTV** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation:<br>General Liability through Alliance of Nonprofits for Insurance, for limits of coverage $1,000,000 each $3,000,000 aggregate with medical expenses of $5,000 for any one person, effective 7/1/2021-7/1/2022<br><br>Workers Compensation through United Wisconsin Insurance Co., with limits of $1,000,000 each/aggregate, effective - 7/1/2021-7/1/2022<br><br>Automobile insurance through Alliance of Nonprofits for Ins., for combined single limit of $1,000,000, effective for 7/1/2021-7/1/2022<br><br>Florida Network is listed as certificate holder on all certificates of coverage. | **No recommendation or Corrective Action.** |
| **Fiscal Practice** | ☐ | ☐ | ☒ | ☐ | ☐ | Documentation:<br>Fiscal Policies and Procedures are contained in the agency's Accounting | **No recommendation or Corrective Action.** |

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| Service Description: Comprehensive Onsite Compliance Monitoring | | | | | | Site Visit Date(s): February 16 – 17, 2022 | |
| | Explain Rating | | | | | | |
| **Major Programmatic Requirements** | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:**<br>**(Attach Supportive Documentation)** |
| a. Agency must have employee and fiscal policy/procedures manuals that are in compliance with GAAP and provide sound internal controls. Agency maintains fiscal files that are audit ready. **PTV** | | | | | | Procedures Manual with a recent revision date of 12/1/2017 and review date of 12/1/2019. The procedures reviewed appear to be consistent with GAAP and provide for limited internal controls. Procedures are included for accounts receivable, cash management, contributions, accounts payable, purchasing, and payroll. | |
| c. Petty cash ledger system is balanced and all cash disbursements are compliant with financial policies and allowable under the contract. (Disbursements/invoices are approved & monitored by management.) –**ON SITE** | ☐ | ☐ | ☒ | ☐ | ☐ | Observation/Documentation:<br>No change in practice was reported for the agency since the last onsite program review in December 2020.<br><br>Petty cash is maintained and reconciled by the Secretary monthly or as needed. The reconciliation is accompanied by a log including the date, vendor, amount, account, and sub-account for each activity.<br><br>Policies and procedures are maintained in the Fiscal Manual under the Cash Management section.<br><br>The maximum petty cash account for WaveCREST shelter is $400. The fund is kept locked up in the Administrative | **No recommendation or Corrective Action.** |

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| | | | | | | | |
| **Major Programmatic Requirements** | **Explain Rating** | | | | | **Ratings Based Upon:**<br>**I = Interview**<br>**O = Observation**<br>**D = Documentation**<br>**PTV = Submitted Prior To Visit**<br>**(List Who and What)** | **Notes**<br>**Explain Unacceptable or Conditionally Acceptable:**<br>**(Attach Supportive Documentation)** |
| | **Unacceptable** | **Conditionally Unacceptable** | **Fully Met** | **Exceeded** | **Not Applicable** | | |
| | | | | | | Secretary's office. Requests for petty cash are informal but are accompanied by an up-to-date log of activities and receipt that is maintained by the custodian. | |
| e. Agency maintains inventory in accordance with a written policy and FNYFS contractual requirements. If over $1,000 inventory has DJJ Property Inventory Number/Tag. In the event the provider has purchased computer equipment an Informational Resources Request (IRR) been submitted to DJJ. **PTV/ON SITE** | ☐ | ☐ | ☐ | ☐ | ☒ | N/A – The agency has not purchased any items with FNYFS monies since the last time on-site. | **No recommendation or Corrective Action.** |
| h. A Single Audit is performed as part of the annual audit if expenses are greater than $500,000. The agency must submit a Corrective Action Plan for findings cited in the management letter and single audit. An annual financial audit was completed within 120 days after the previous fiscal year/calendar year and that a copy was provided to the Network unless and extension has been requested and approved in writing. Copy of Audit is submitted to the FNYFS by December 31st. **Obtain from FNYFS** | ☐ | ☒ | ☐ | ☐ | ☐ | Documentation:<br>The agency's controller provided a letter dated December 29, 2021, stating the auditors are still in the process of completing the Single Audit for the FY ended June 30, 2021, due to delays in obtaining confirmations from several funding agencies. It is expected the audit report and management letter will be completed by the end of February 2022. Financial audit conducted for year ending June 30, 2020, and 2019 was completed by RSM US LLP October 30, 2020. A separate Management Letter requiring a Corrective Action Plan was not issued by the auditor. Per the | **Recommendation**<br>Submit a copy of the Single Audit for the FY ending June 30, 2021, to the Florida Network immediately upon receipt of the audit report and management letter. |

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| | Explain Rating | | | | | | |
| Major Programmatic Requirements | Unacceptable | Conditionally Unacceptable | Fully Met | Exceeded | Not Applicable | Ratings Based Upon:<br>I = Interview<br>O = Observation<br>D = Documentation<br>PTV = Submitted Prior To Visit<br>(List Who and What) | Notes<br>Explain Unacceptable or Conditionally Acceptable:<br>(Attach Supportive Documentation) |
| | | | | | | Residential Supervisor, a copy of the audit for the previous fiscal year was submitted to the FNYFS. | |

## CONCLUSION

CHS WaveCREST has conditionally met the requirements for the CINS/FINS contract as a result of compliance with three of four applicable indicators of the Modified Administrative and Fiscal Contract Monitoring Tool. One of the five indicators was not applicable because the provider does not have any current inventory purchased with DJJ/FN Funds. Consequently, **the overall compliance rate for this contract monitoring visit is 75%.** There are no corrective actions cited; however, one recommendation is made as a result of the pending completion of the Single Audit that is overdue based on contract requirement. Overall, the provider is performing satisfactorily in meeting the fiscal and administrative terms of its contract. In addition, the majority of indicators reviewed were carried out in a manner which meets the standard as described in the report findings.

### SUMMARY OF RECOMMENDATIONS

**Recommendation**
Submit a copy of the Single Audit for the FY ended June 30, 2021, to the Florida Network immediately upon receipt of the audit report and management letter.

If required, the provider must submit a corrective action plan to address corrective actions cited in the corresponding section of this report. The provider's Corrective Action Plan should address the issues, corrective actions item cited, time frames and staff responsible. Responses to items cited for corrective actions are due to the Florida Network and the Florida Network Contract Manager within fourteen (14) working days of receipt of this report (See Florida Network Site for the Service Provider Corrective Action Form). The Florida Network Contract Manager will then review the response to the corrective action(s) to determine if the response adequately addresses the problem identified in the report within three (3) days. Upon approval the provider will then implement the approved measure to address the item(s) cited in the report. If the corrective action is successful in resolving the items cited in the report the contract monitor will notify the Provider in writing that the desired resolution has been achieved. Log on to the Florida Network (www.floridanetwork.org) website forms section and download the Service Provider Corrective Action Tracking Form.

One (1) recommendation is made; however, it does not require a corrective action plan.

# Florida Network of Youth and Family Services Quality Improvement Program Report

Review of CHS – WaveCREST
CINS/FINS Program

February 16-17, 2022

**Compliance Monitoring Services Provided by**

# CINS/FINS Rating Profile

Standard 1: Management Accountability

| | |
|---|---|
| **1.01 Background Screening** | **Satisfactory** |
| **1.04 Training Requirements** | **Limited** |
| **1.06 Client Transportation** | **Satisfactory** |

**Percent of indicators rated Satisfactory: 66.67 %**
**Percent of indicators rated Limited: 33.33 %**
**Percent of indicators rated Failed: 0 %**

Standard 2: Intervention and Case Management

| | |
|---|---|
| **2.03 Case/Service Plan** | **Satisfactory** |
| **2.04 Case Management & Service Delivery** | **Not Applicable** |

**Percent of indicators rated Satisfactory: 100 %**
**Percent of indicators rated Limited: 0 %**
**Percent of indicators rated Failed: 0 %**

Standard 3: Shelter Care & Special Populations

| | |
|---|---|
| **3.01 Shelter Environment** | **Satisfactory** |
| **3.06 Staffing and Youth Supervision** | **Satisfactory** |

**Percent of indicators rated Satisfactory: 100 %**
**Percent of indicators rated Limited: 0 %**
**Percent of indicators rated Failed: 0 %**

Standard 4: Mental Health/Health Services

| | |
|---|---|
| **4.02 Suicide Prevention** | **Satisfactory** |
| **4.03 Medications** | **Satisfactory** |

**Percent of indicators rated Satisfactory: 100 %**
**Percent of indicators rated Limited: 0 %**
**Percent of indicators rated Failed: 0 %**

## Overall Rating Summary

**Percent of indicators rated Satisfactory: 88.89 %**
**Percent of indicators rated Limited: 11.11 %**
**Percent of indicators rated Failed: 0 %**

## Rating Definitions

Ratings were assigned to each indicator by the review team using the following definitions:

| | |
|---|---|
| Satisfactory Compliance | No exceptions to the requirements of the indicator; limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or exceptions with corrective action already applied and demonstrated. |
| Limited Compliance | Exceptions to the requirements of the indicator that result in the interruption of service delivery, and typically require oversight by management to address the issues systemically. |
| Failed Compliance | The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery. |
| Not Applicable | Does not apply. |

## Reviewers

Members

Marcia Tavares - Lead Reviewer Consultant-Forefront LLC/Florida Network of Youth and Family Services
Baldwin Davis - Consultant-Forefront LLC/Florida Network of Youth and Family Services
Christine Calvert - Department of Juvenile Justice

# Methodology

This modified review was conducted in accordance with FDJJ-1720 (Quality Assurance Policy and Procedures), and focused in particular areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Shelter Care/Health Services, and (4) Mental Health/Health Services, which are included in the Children/Families in Need of Services (CINS/FINS) Standards (effective January 2022).

## Persons Interviewed

| | | | | | |
|---|---|---|---|---|---|
| | Chief Executive Officer | | Case Manager | | Nurse – Full time |
| | Chief Financial Officer | | Counselor Non-Licensed | X | Nurse – Part time |
| | Chief Operating Officer | | Advocate | | # Case Managers |
| | Executive Director | | Direct – Care Full time | 1 | # Program Supervisors |
| X | Program Director | | Direct – Part time | | # Food Service Personnel |
| | Program Manager | | Direct – Care On-Call | | # Healthcare Staff |
| X | Program Coordinator | | Intern | | # Maintenance Personnel |
| X | Clinical Director | | Volunteer | | # Other (listed by title): ___ |
| | Counselor Licensed | | Human Resources | | |

## Documents Reviewed

| | | | | | |
|---|---|---|---|---|---|
| | Accreditation Reports | X | Table of Organization | | Visitation Logs |
| X | Affidavit of Good Moral Character | X | Fire Prevention Plan | X | Youth Handbook |
| X | CCC Reports | | Grievance Process/Records | | # Health Records |
| X | Logbooks | | Key Control Log | 4 | # MH/SA Records |
| | Continuity of Operation Plan | X | Fire Drill Log | 5 | # Personnel /Volunteer Records |
| X | Contract Monitoring Reports | | Medical and Mental Health Alerts | 6 | # Training Records |
| | Contract Scope of Services | X | Precautionary Observation Logs | 6 | # Youth Records (Closed) |
| X | Egress Plans | X | Program Schedules | 2 | # Youth Records (Open) |
| X | Fire Inspection Report | X | List of Supplemental Contracts | | # Other: ___ |
| | Exposure Control Plan | | Vehicle Inspection Reports | | |

## Observations During Review

| | | | | | |
|---|---|---|---|---|---|
| | Intake | X | Posting of Abuse Hotline | | Staff Supervision of Youth |
| | Program Activities | X | Tool Inventory and Storage | X | Facility and Grounds |
| | Recreation | X | Toxic Item Inventory & Storage | X | First Aid Kit(s) |
| | Searches | | Discharge | | Group |
| | Security Video Tapes | | Treatment Team Meetings | | Meals |
| | Social Skill Modeling by Staff | | Youth Movement and Counts | X | Signage that all youth welcome |
| | Medication Administration | X | Staff Interactions with Youth | X | Census Board |

## Comments

Due to COVID-19, this review was conducted onsite using the modified QI Review plan.

Monitoring Purpose:

The purpose of this monitoring is to provide an annual quality improvement program review. This is to verify the agency adheres to all current CINS/FINS standards and contract compliance requirements for residential and non-residential services.

Strengths and Innovative Approaches

Since the last QI review in December 2020, the provider has obtained the following equipment to enhance services to youth in the shelter:
- New Washer and Dryer
- New exercise equipment donated by Children Services Council

Programming and staffing changes include the loss of two positions, Administrative Assistant and a Data Management Specialist. The former Administrative Assistant had been with the agency for over 15 years and resigned in March 2021. The position was vacant for 4 months before filling. The agency also lost its Data Management Specialist in July 2021 and have just filled the position on 2/2/2022.

In an effort to be more competitive, Children's Home Society (CHS) increased the starting wages for Youth Care Specialists to $14.00 per hour. The agency is also in the process of increasing the Case Manager II positions to also be competitive. This has helped with recruitment and retention; however, there are two current vacancies for a fulltime youth care staff and a case manager II position.

Deficiencies/ Challenges
- Parking lot needs improvement
- Lack of applicants for vacancies
- Delays in the hiring process after recruiting potential candidates

Narrative Summary

CHS WaveCREST provides residential and non-residential counseling and case management services across four counties-- Indian River, Okeechobee, Martin, and St. Lucie, in Circuit 19. CHS WaveCREST is managed by an Executive Director and a Director of Program Operations. Day-to-day activities in the youth shelter are managed by a Residential Supervisor. The community counseling program is managed by a CINS/FINS Non-Residential Supervisor who is a Licensed Mental Health Counselor (LMHC). At the time of the onsite visit, the shelter youth census was seven youth.

A total of eight indicators were reviewed during the modified QI visit. These indicators include: 1.01 - Background Screening, 1.04 – Training, 1.06 – Transportation, 2.03 – Case/Service Plan, 3.01 – Shelter Environment, 3.06 – Staffing and Youth Supervision, 4.02 – Suicide Prevention, and 4.03 – Medication.

The overall findings for the modified QI Review for CHS WaveCREST are summarized as follows:

Standard 1

Three indicators were reviewed for this standard. Two of the three indicators 1.01 and 1.06 were rated satisfactory with no exceptions. Indicator 1.04 received a limited rating due to training deficiencies observed for three first year staff and two in-service staff.

Standard 2
Only one indicator was reviewed for standard 2. Indicator 2.03 was rated satisfactory with no exceptions.

Standard 3
Two indicators were reviewed for standard 3, indicators 3.01 and 3.06. Indicator 3.06 was rated satisfactory with no exceptions; however, there were exceptions noted for indicator 3.01 that were observed during the facility tour as follows: 1) a tree root in front of building is causing concrete to shift and creates a trip hazard; 2) there is no airbag deflator in van; Per DPO, airbag deflators are no longer sold and program has not been able to purchase it; 3) first aid kits are kept in shelter and not in the vans. There is no documentation on first aid log or transportation log to support they are taken to the vans when youth are being transported; and 4) food inspection and residential Group Care Inspection expired on 01.08.2022. The renewal was initiated by the program on 02.04.2022, after the inspection expiration date.

Standard 4
There are 2 indicators that are reviewed for standard 4, 4.02 and 4.03. Both indicators were rated satisfactory with no exceptions.

Summary of Deficiencies resulting in Limited Rating:

**Standard 1:**
**Indicator 1.04 – Limited**
Training records for three first year staff revealed none of the three completed all mandatory trainings required in the first 90 days of hire. One staff did not complete 6 required topics during the 90-day timeframe and was missing one training as of the onsite visit. The other two first year staff are outside the 90-day timeframe and have not yet completed Medication Distribution training by the nurse. Additionally, two of three in-service staff did not complete all annual required trainings. One of the two staff did not complete 5 trainings and the other staff did not complete 2 of the 11 required trainings for 2021. Also, one of three in-service staff did not complete the 40 training hours required annually.

# CINS/FINS QUALITY IMPROVEMENT TOOL

| Quality Improvement Indicators: | Satisfactory (S) | Non-compliant (E) | No Eligible Items for Review (N) | No Practice (NP) | Not Applicable (N/A) | Review Based Upon Document Source | Notes |
|---|---|---|---|---|---|---|---|
| **Standard One – Management Accountability** | | | | | | | |
| **1.01: Background Screening (BS) and compliance with DJJ OIG statewide procedures regarding BS of employees, contractors and volunteers** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.01** | | | | | | **YES**<br>If NO, explain here:<br>CHS/7101 was approved 12/1/2021 by the Director of Program Operations. | |
| Agency utilizes an employee suitability prescreening assessment with a passing rate criterion prior to an offer of hire for direct care staff working with youth or the agency has provided an explanation for staff hired with a non-passing/low score. | X | | | | | A total of three new staff were hired since the last onsite QI review. All three staff met the criteria for a pre-screening assessment. The agency uses the Berke Assessment and completed the screening prior to hire for all three staff. Two of the three staff received a passing score. Documentation was provided to support management completed a satisfactory behavioral assessment to justify the hiring of one staff who had a low score on the Berke Assessment. | |
| Background screening completed prior to hire/start date or exemption obtained prior to working with youth (if rated ineligible) for new hires, volunteers/interns, and contractors | X | | | | | Eligible DJJ background screening results for three new staff hired demonstrated staff were background screened prior to hire. The program did not utilize any volunteers during the review period. | |
| Agency has evidence for employees who have had a break in service and who are in good standing and reemployed with the same agency without an additional suitability assessment or background screening if the break is less than 90 days. | | | X | | | None of the new staff were previously employed by the program. | |
| Five-year re-screening completed every 5 years from initial date of hire | X | | | | | There were two staff due for five-year re-screening during the review period. Both staff had re-screening completed within the required time frame. | |
| Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) is completed and sent to BSU by January 31st? | X | | | | | The agency submitted the Annual Affidavit of Compliance with Level 2 Screening via email to the Background Screening Unit on 12/2/2021 prior to the January 31, 2022 submission deadline. | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Proof of E-Verify for all new employees obtained from the Department of Homeland Security | X | | | | | Documentation of approval of E-Verify work eligibility was provided for all three new staff hired. | |
| **1.04: Training Requirements (Staff receives training in the necessary and essential skills required to provide CINS/FINS services and perform specific job functions)** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.04** | | | | | | **NO**<br>If NO, explain here: The agency's training plan is not updated to reflect current list of mandatory training topics to be completed within the required 90-day timeframe.<br>CHS/7104 was approved 12/22/2021 by the Director of Program Operations. | |
| Rating Criteria | Satisfactory | Non-compliant | No Eligible Items for Review | No Practice | Not Applicable | | |
| **First Year Direct Care Staff** | | | | | | | |
| All staff completed the United States Department of Justice (DOJ) Civil Rights & Federal Funds training within 30 days from date of hire. *(Staff hired before January 1st were required to complete no later than December 31, 2020)* | X | | | | | Three applicable first year training records were reviewed. The three staff completed the DOJ Civil Rights training within thirty days of hire. | |
| All staff receives all mandatory training during the first 90 days of employment from date of hire. | | X | | | | There were three first year direct care staff files reviewed and all three had more than 80 hours of training required; however, none of the three staff had completed all of the mandatory trainings required during the first 90 days of hire. | Limited Exception: One of the three new staff did not complete seven required training topics within the 90-day timeframe required; however, two of the seven training courses (Motivational Interviewing and PAT) were not offered in person by DJJ but were completed by staff as soon as they were made available. The other two first year staff are outside the 90 day timeframe and have not yet completed Medication Distribution training. |
| **Non-licensed Mental Health Clinical Shelter Staff (within first year of employment)** | | | | | | | |
| Non-licensed mental health clinical shelter staff Assessment of Suicide Risk Training | | | X | | | There were no non-licensed clinical staff hired requiring this training during the review period. | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Documentation of non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form or written confirmation by a licensed mental health professional of training (includes date, signature and license number of the licensed mental health professional supervisor). | | | X | | | There were no non-licensed clinical staff requiring this training during the review period. | |
| **In-Service Direct Care Staff** | | | | | | | |
| Direct care staff completes 24 hours of mandatory refresher Florida Network, SkillPro, and job-related training annually *(40 hours if the program has a DCF child caring license).* | | X | | | | Three in-service employee training files were reviewed. Two of the three staff completed over 40 hours of training. One of the three staff completed all mandatory annual training topics. | Limited Exception:<br>One of the two in-service staff did not complete 5 annual required trainings and the second staff did not complete 2 annual required training.<br><br>One of the three in-service staff completed only 19.3 hours out of the 40 hours required annually. |
| **Required Training Documentation** | | | | | | | |
| The program maintains an individual training file for each staff, which includes an annual employee training hours tracking form and related documentation, such as certificates, sign-in sheets, and agendas for each training attended. | X | | | | | All six training files reviewed were maintained in individual binders and included a training log that documented trainings, date completed, and hours. The binders also contained training certificates and training worksheets that are neatly organized and separated by training year. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 1.06** | | | | | | **YES**<br>If NO, explain here:<br>CHS/7106 was approved 12/2/2021 by the Director of Program Operations. | |
| Approved agency drivers are agency staff approved by administrative personnel to drive client(s) in agency or approved private vehicle | X | | | | | Per residential supervisor, all direct care staff are approved agency drivers. | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Approved agency drivers are documented as having a valid Florida driver's license and are covered under company insurance policy | X | | | | | A review of the agency's automobile insurance policy documented liability insurance coverage provided through Alliance Nonprofits for Insurance with combined single limits of $1,000,000 which the residential supervisor stated includes coverage for all agency drivers. | |
| Agency's Transportation policy prohibit transporting a client without maintaining at least one other passenger in the vehicle during the trip and include exceptions in the event that a 3rd party is NOT present in the vehicle while transporting | X | | | | | Reviewed policy titled CHS/7106 Client Transportation. | |
| In the event that a 3rd party cannot be obtained for transport, the agency's supervisor or managerial personnel consider the clients' history, evaluation, and recent behavior | X | | | | | A total of 26 single transports occurred during the period. All 26 transports were documented as approved on the transportation logs by the supervisor. Staff also documents single transport in the logbook. A review of the logbook shows one of the 26 single transports was not documented as approved and two of the single transports were not captured in the logbook. | |
| The 3rd party an approved volunteer, intern, agency staff, or other youth | X | | | | | Reviewed policy titled CHS/7106 Client Transportation and transportation logs for the review period. | |
| There is documentation of use of vehicle that notes name or initials of driver, date and time, mileage, number of passengers, purpose of travel and location. | X | | | | | All logs documented the required information and were filled out in their entirety. | |
| **Standard Two – Intervention and Case Management** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 2.03** | | | | | | **YES**<br>If NO, explain here:<br>CHS/7201 Screening Eligibility for Services and Intake Assessments was reviewed by the Director of Operations on 12/30/20, policy CHS/7202 Network Inventory of Risks, Victories, and Needs (NIRVANA) and CHS Needs Assessments was reviewed by the Director of Operations on 12/22/2021, and policy CHS7203 Service Case Plans Implementation, Review, and Revision was reviewed by the Director of Operations on 12/22/2021. | |
| Rating Criteria | Satisfactory | Non-compliant | No Eligible Items for Review | No Practice | Not Applicable | | |

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| Case/Service plan is developed within 7 working days of NIRVANA | X | | | | | A review of six plans indicated the case plan was created within seven days of the needs assessment without exception. | |
| **Case plan service Plan includes:**<br><br>1. Individualized and prioritized need(s) and goal(s) identified by the NIRVANA<br><br>2. Service type, frequency, location<br>3. Person(s) responsible<br>4. Target date(s) for completion and Actual completion date(s)<br>5. Signature of youth, parent/ guardian, counselor, and supervisor<br>6. Date the plan was initiated | X | | | | | A review of two closed and one open residential and two closed and one open community counseling records indicated all elements were included. One record was applicable for having a case plan recently developed. The case notes reflected the parent/guardian participated in the development of the plan and was scheduled to sign the document during the next on-site visit. All six reviewed records contained a case plan which included prioritized needs derived from the needs assessment results. All goals indicated the service type, frequency, location, person responsible, target dates for completion, and date of plan initiation. All plans were signed by the counselor and youth. | |
| Case/service plans are reviewed for progress/revised by counselor and parent (if available) every 30 days for the first three months and every 6 months after | X | | | | | Three plans documented a weekly review of the plan, two documented a monthly review of the plan, and the last record review was not yet due. | |
| **Standard Three – Shelter Care** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.01** | | | | | | **YES**<br>If NO, explain here:<br>Policy and Procedure #CHS/7301 titled Shelter Environment was reviewed and signed by the Director of Program Operations on 12/03/2021. | |
| **Rating Criteria** | Satisfactory | Non-compliant | No Eligible Items for Review | No Practice | Not Applicable | | |

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| **Facility Inspection** | | X | | | | On site tour of the facility revealed furnishings were adequate and functional to serve the shelter's expectation. The facility appeared to be free of any termite or insect infestation. Each youth has their own individual bed with clean, covered mattress, pillow, and sufficient linens. The bathrooms were clean. Current DCF license and COA accreditation certification were displayed in the lobby area.<br><br>No graffiti were observed and the lighting was adequate throughout, doors were secure and required key access, including external fence gates. Egress plans were posted in several locations along with grievance process and forms, grievance box, abuse hotline number and DJJ Incident Reporting numbers. The laundry room had functional washers and dryers that were clean and clean of lint as well as the laundry room was organized, clean and well kept. Chemicals were stored in a locked cabinet and labelled when necessary, inventories and MSDS were maintained.<br><br>The grounds were very well landscaped and evidently well maintained. Dumpster and garbage cans were covered. Agency and other private vehicles were locked. Agency vehicles contained some required equipment including fire extinguisher, seat belt cutter glass breaker and flashlight. There were no signs of contraband and while Chevrolet van was very dirty, it appeared to be free of hazardous items. The two agency vehicles are a Ford Transit 12 seater and is a 2020-year model which is used frequently; Chevrolet Express 12 seater is a 2007-year model and is used primarily as a backup vehicle. | Exceptions:<br>The faucets in the female dorm lacks adequate hot water and which staff indicated they would follow up with their maintenance contractors. Two functional bathrooms on both male and female side do not have running hot water as they have no connecting hot water pipes, a historic arrangement.<br><br>There is no airbag deflator which staff indicates they are unable to purchase and the first aid kit for the van is kept in shelter and taken out when it's to be used. However, the last time the first aid kit was logged as signed out was on 12/10/2021 at 4:22 p.m. and returned at 4:44 p.m. by staff. From the logs reviewed it showed multiple trips taken with youth, occurring between 12/10/2021 and 02/16/2022. The van logs are not titled to indicate which vans they relate to. |

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| **Additional Facility Inspection Narrative (if applicable)** | | | | | | | Exceptions:<br>There was an instance where a particular chemical (sanitizer) was placed in a spray bottle and not properly labeled with the exact name to match the MSDS; that was immediately corrected by staff. Chemicals are inventoried however the inventory does not indicate a tally or final count of new items that are introduced.<br><br>A sizeable length of construction underground sewer pipe was left outside to the side of the building after recent sewer reconstruction.<br><br>The tree at the entrance of the facility have roots that are compromising the walkway to create an existing trip hazard. |
| **Fire and Safety Health Hazards** | | X | | | | All annual fire inspections are up to date and fire system check was completed on 1/12/2021. Semiannual fire suppression check was done on 12/07/2021 and all fire extinguishers are labelled accordingly to reflect the last inspection. Fire and emergency drills are completed and logged each month and all are completed within the two-minute time requirements. Mock drills are also done, reviewed and signed off by the Shelter Manager.<br><br>The agency has a combined Department of Health Food and Residential Group Inspection that is posted but was expired on 1/08/2022. Posted menus are reviewed and signed by dietician annually. The fridge and freezers are operable and have the correct and desirable working temperatures. | Exception:<br>Staff have provided evidence that the Department of Health Inspection was requested to be done, however the request was sent on Friday 2/04/2022, that is after the expiration date of 1/8/2022. |
| **Additional Fire and Safety Health Hazards Narrative (if applicable)** | | | | | | | |
| **Youth Engagement** | | | | | | | |

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| a. Youth are engaged in meaningful, structured activities (e.g., education, recreation, counseling services, life and social skill training) seven days a week during awake hours. Idle time is minimal.<br><br>b. At least one hour of physical activity is provided daily.<br><br>c. Youth are provided the opportunity to participate in a variety of faith-based activities. Non-punitive structured activities are offered to youth who do not choose to participate in faith-based activities.<br><br>d. Daily programming includes opportunities for youth to complete homework and access a variety of age appropriate, program approved books for reading. Youth are allowed quiet time to read.<br><br>e. Daily programming schedule is publicly posted and accessible to both staff and youth. | X | | | | | The agency has a program schedule to indicate that a group program occurs each day; they are posted in the main office, hallways and youth rooms. There was no recreational schedule to show that youth had physical activity planned during the day. However, staff states that activities occur but with restrictions due to current COVID 19 corporate policy directive. Daily programming includes an educational component as youth are also able to use the computer lab to assist in their educational pursuits. There is no evidence to suggest that youth is restricted from their preferences of religious practices. One youth who remained on site was observed being supported and engaging appropriately with staff throughout the day. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 3.06** | | | | | | **YES**<br>If NO, explain here:<br>Policy CHS/7306 titled Staffing and Youth supervision was reviewed by the Director of Operations on 12/3/2021.<br>□ | |
| **Rating Criteria** | Satisfactory | Non-compliant | No Eligible Items for Review | No Practice | Not Applicable | | |
| The program maintains minimum staffing ratios as required by Florida Administrative Code and contract.<br><br>• 1 staff to 6 youth during awake hours and community activities<br><br>• 1 staff to 12 youth during the sleep period | X | | | | | Program has a 12 bed maximum capacity. The program mandates two staff for each shift. Program maintains an on-call roster and on call supervisor listing. Policy states "staff shall not leave until next shift arrives." Documentation in the logbooks and "client location and daily census log" for the past twelve months validated ratio adherence. | |

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| All shifts must always provide a minimum of two staff present | X | | | | | Two staff (minimum) are scheduled for each shift. On call supervisory and direct care staff are available. Program documentation and schedules verified practice in in accordance with policy. | |
| Program staff included in staff-to-youth ratio includes only staff that are background screened and properly trained youth care workers, supervision staff, and treatment staff | X | | | | | All program staff on the staff schedule were background screened. Direct care and supervisory staff are trained in accordance with the CINS/FINS approved training plan. | |
| The staff schedule is provided to staff or posted in a place visible to staff | X | | | | | The staff schedule is posted in staff area and supervisory office. | |
| There is a holdover or overtime rotation roster which includes the telephone numbers of staff who may be accessed when additional coverage is needed | X | | | | | The program maintains an on-call supervisor list and a staff on-call list. Additionally, the policy and job descriptions dictate staff shall not leave their post until relieved.□ | |
| Staff observe youth at least every 15 minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness or room restriction | X | | | | | The program's Client Location and Census Log is maintained 24 hours daily and documents youth checks twice during each thirty-minute block in addition to staff assigned and movement activities (i.e. school). The program's logbooks and sight and sound supervision logs also support staff maintain ten-minute supervision intervals during sleeping hours.<br><br>Physical Layout of the program: The program is divided by gender with the male youth sleeping on the south side and female youth sleeping on the north side. Each room has two beds and there is one room on each side with a third bed. Due to COVID-19 the program has maintained single occupancy rooms. The program also maintains a sight and sound supervision sleeping bed within the main dayroom area of the program. | |
| **Standard Four – Mental Health/Health Services** | | | | | | | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.02** | | | | | | **YES**<br>If NO, explain here:<br><br>The CHS CINS/FINS Program Comprehensive Master Plan for Access to Mental Health and Substance Abuse Services and policy CHS/7402 Identification of Suicide Risk and Shelter Prevention were both signed by the Director of Program Operations on 12/3/2021.□ | |
| Rating Criteria | Satisfactory | Non-compliant | No Eligible Items for | No Practice | Not Applicable | | |

| Rating Criteria | Satisfactory | Non-compliant | Items for Review | No Practice | Not Applicable | | |
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| **Suicide Risk Screening and Approval** | | | | | | | |
| Suicide risk screening occurred during the initial intake and screening process. Suicide screening results reviewed and signed by the supervisor and documented in the youth's case file. | X | | | | | A review of four youth records indicated each youth was screened for suicide risk upon admission and during the intake process. Each screening was reviewed and signed by a supervisor and maintained in the youth record as required. | |
| The program's suicide risk assessment has been approved by the Florida Network of Youth and Family Services | X | | | | | The program uses the approved Assessment of Suicide Risk (ASR). | |
| **Supervision of Youth with Suicide Risk** | | | | | | | |
| Youth are placed on the appropriate level of supervision based on the results of the suicide risk assessment. | X | | | | | A review of four youth records reflected each youth was placed on supervision aligned with their individual screening and Assessment of Suicide Risk results. | |
| Staff person assigned to monitor youth documented youth's behavior at 30 minute or less intervals | X | | | | | Each of the four youth records were applicable for being placed on sight and sound supervision. Each log documented the staff member exceeded the thirty minutes and completed checks at ten-minute intervals. | |
| Supervision level was not changed/reduced until a licensed professional or a non-licensed mental health professional under the supervision of a licensed professional completed a further assessment OR Baker Act by local law enforcement | X | | | | | A review of four youth records reflected each was administered an ASR. One was completed by the licensed clinical social worker (LCSW) and three were completed by the bachelor's level mental health staff supervised by the licensed professional. The three ASRs completed by the BA staff clearly documented concurrence with recommendations prior to a change in supervision. | |
| **Provider has a written policy and procedure that meets the requirement for Indicator 4.03** | | | | | | **YES**<br>If NO, explain here:<br>Policy CHS/7403 titled Medications was signed by the Director of Program Operations on 6/5/2021. | |
| **Rating Criteria** | Satisfactory | Non-compliant | No Eligible Items for Review | No Practice | Not Applicable | | |
| **Medication Storage** | | | | | | | |

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| a. All medications are stored in a Pyxis Med-Station 4000 Medication Cabinet that is inaccessible to youth (when unaccompanied by authorized staff)<br>b. Pyxis machine is stored in accordance with guidelines in FS 499.0121 and policy section in Medication Management<br>c. Oral medications are stored separately from injectable epi-pen and topical medications<br>d. Medications requiring refrigeration are stored in a secure refrigerator that is used only for this purpose, at temperature range 2-8 degrees C or 36-46 degrees F. (If the refrigerator is not secure, the room is secure and inaccessible to youth.)<br>e. Narcotics and controlled medications are stored in the Med-Station<br>f. Pyxis keys with the following labels are accessible to staff in the event they need to access medications if there is a Pyxis malfunction: a TOP COVER b BACK PANEL- LEFT TALL CABINET LOCK- LEFT, c BACK PANEL- RIGHT TALL CABINET LOCK- RIGHT | X | | | | | Observation of the medication room with Pyxis Med Station, Pyxis keys (backup keys), medication refrigerator (temp 36 degrees), "medical log records", weekly and perpetual inventories of OTC and sharps, monthly Pyxis review process, and sharps storage was conducted with no exceptions. The center reported no incidents of medication reconciliation needed due to inaccurate counts since the last annual review. Reviewer observed inventories of sharps and medication were accurate.<br><br>The medication refrigerator is stored in the pantry under two locks; however the program did not have any medication requiring refrigeration at the time of the onsite review. | |
| **Medication Distribution** | | | | | | | |
| a. Agency maintains a minimum of 2 Super Users for the Med-Station<br>b. Only designated staff delineated in User Permissions have access to secured medications, with limited access to controlled substances (narcotics) | | | | | | Pyxis superusers (3) are the nurse, residential supervisor, and group living manager. The nurse works part time on Tuesday and Sunday for approximately 5 hours each week. The center is working on hiring a second RN.<br><br>The center has eight staff trained to assist youth in the self-administration of medication. A medication log is used to document distribution of medication.<br><br>Medication verifications is conducted by the nurse or admitting staff | |

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| c. A Medication Distribution Log shall be used for distribution of medication by non-licensed and licensed staff<br>d. Agency verifies medication using one of four methods listed in the FNYFS Operations Manual<br>e. When nurse is on duty, medication processes are conducted by the nurse<br>f. The delivery process of medications is consistent with the FNYFS Medication Management and Distribution Policy<br>g. Agency does not accept youth currently prescribed injectable medications, except for epi-pens<br>h. Non-licensed staff have received training in the use of epi-pens provided by a registered nurse | X | | | | | by calling the pharmacy and is documented in the youth record.<br><br>The center does not accept youth prescribed injectable medications. Epinephrine Auto Injector annual trainings were conducted by staff through the Florida Network Bridge training portal. | |
| **Medication Inventory** | | | | | | | |
| a. For controlled substances, a perpetual inventory with running balances is maintained as well as a shift-to shift count verified by a witness and documented<br>b. Over-the-counter medications that are accessed regularly are inventoried weekly by maintaining a perpetual inventory<br>c. Syringes and sharps (needles, scissors, etc.) are secured, and counted and documented weekly | X | | | | | One youth was on controlled medication during the review and the count was accurate. All reviewed closed records contained documentation of shift to shift counts for controlled medication. | |
| There are monthly reviews of medication management practice via Knowledge Portal or Pyxis Med-Station Reports. | X | | | | | The nurse prints monthly reports indicating review and maintains the reports in a binder at the center. | |
| Medication discrepancies are cleared after each shift. | | | X | | | None reported since the last annual compliance review. | |